Paper 2

A Case of Clinical Reflective Writing: A Rainbow draft

Della Fish and Linda de Cossart

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The text below is an example of *Clinical Reflective Writing (CRW).* The bold black text is the original account of the case offered by a consultant. The coloured text has been added later when the consultant was encouraged, for the purpose of their own exploration and for recognising what would be needed to share with learners about this case, to expand on what had been in their thoughts during the event and what had driven their decisions. The '*rainbow draft*' then is considerably longer and *the invisibles (context; professionalism; forms of knowledge; Clinical thinking; professional judgements; seeing the wider perspective and beyond the immediate and the therapeutic relationship)* are now more explicit in the coloured text, rather than tacit and left to the reader to imagine as in the original. The key to the colours in the text and *the invisibles* is below. A sequel to the main story is added at the end.

Context	**Blue**
Professionalism	**Green**
Knowledge	**Red**
CTP	**Purple**
PJ	**Brown**
Seeing wider	**Grey**
Therapeutic relationship	**Turquoise**

The Case

It was 3.45pm on a Friday afternoon and my surgical team and I were nearing the end of the business ward round, following a busy night on call. In the corridor outside the final ward, my registrar called me aside and told me that one of the patient's, Mrs. X, a 62-year-old, was admitted yesterday with abdominal pain. She had a history of cardiac problems and had recently been admitted to hospital on several occasions for this problem. An ultrasound done yesterday had shown multiple liver metastases not amenable to operative treatment and a CT scan had then been done. It had been a busy week. The Friday afternoon ward round, to tidy up things before the weekend, is an important part of our routine. This kind of event is often a heart-sink event that happens late in the day when it can become difficult to get things sorted out. I believe that I showed my professionalism

by not shirking this case and leaving it to the team to sort out. I decided to see the lady. **The story continued to unfold. Last night the ward doctor had talked to her about the ultrasound result and that the CT result would not be available until Monday. She became very angry and upset.** My experience (a form of knowledge) told me that this was not an uncommon scenario and that I needed to support my team by seeing the lady. **As my registrar was talking the ward clerk came out of the ward towards us and gave me the CT result which she had just printed out from the computer. It confirmed the ultrasound findings.** These results contributed to the (factual) knowledge that I needed in order to make a professional judgement about how to precede**.** My mind was now on what I was going to say to the woman (I believe this demonstrates the deliberative side of my decision making by weighing up competing and complex issues which are: it being Friday afternoon and I was keen to get away on time; my trainees were in receipt of all the information needed and had a plan; the patient had already been upset; was there anything I could really do?) I made a professional judgement that I would be as honest with the patient and be sensitive to what she needed from me. **We all walked into the ward and I approached the bedside and introduce myself to the patient and her husband who was with her.** The context here is of a senior consultant meeting for the first time with a patient. Patients often react differently to consultants than too other members of the team and I knew from experience that I was unlikely to get the same response but I needed to be aware that it might happen. **I sat on the bed and ask the patient about what she remembered of the discussions she had had with my staff the night before.** This was a personal professional judgement to allow the patient to take the floor and lead the conversation as well as my way of trying to gain a rapport with this woman who I was meeting for the first time and with whom I needed to create a therapeutic relationship. **She replied calmly, recalling most of the information given. She said that she wanted to be told the truth and to go home. She repeated that she knew that the CT scan was not ready and that that would be the final truth. She wanted to be sure that everyhting possible would be done. She then continued to tell me about her family and how supportive and loving they were. She explained that she was worried for them.**

I confirmed the accuracy of her recall of events and told her that the results of the CT were now available - earlier than expected. Before continuing, I made a judgement to sense her

mood and let that decide how I would continue**. I told her the diagnosis of secondary liver cancer and confirmed that neither operative treatment nor chemotherapy will help to cure it. In my mind I knew that this lady and her husband were in agony I was imagining how they might feel; I tried to tell myself that it was not actually my fault she had terminal cancer and that my responsibility was to give her the opportunity to face this most difficult moment of her life as she wished My professionalism took over and I became the expert consultant. I waited for her to speak.**

Mrs. X remained calm and asked 'how long have I got? At this point her husband joined the conversation and reaching out for his wife's hand asked 'Can anything be done? Surely there is some hope? I continued in a firm but sensitive voice aware that the therapeutic relationship that I was making needed to be consolidated to make this consultation a good one for us all. I was not entirely surprised that she was calm with me, it is well known that patients do accept things better from 'the boss', it is of course also true that I was not giving her the news for the first time, and that probably maked my task and her response easier. It did not take away from me, inside, the feeling that I want to be a million miles away. I was also aware that I had a responsibility to my staff in supporting what they had already done for this patient. I recognised that I must not be in too much of a hurry to rush away. I must allow her time to ask questions, and more importantly, to understand the next move and her follow up. (Insight, imagination and self-knowledge). **I explained that a cure was not possible but that everything would be done to help the pain and make her comfortable. I also explained that everything was happening in a rush and she would need time to consider things more fully and we would do what we could to help. She had only just become acquainted with us all.** I think this showed my ability to think beyond this moment and to take control and begin to list the things that needed to be put in place for her care. **She took control of events at this point and said that she wanted to go home. The decision was agreed that she should go home and the ward nurse was to make arrangements for Macmillan nurse visits in the next week. An arrangement was also made for her to return to my clinic for a further opportunity to talk things through the following Friday.** The context of the ward for 'breaking bad news' is always difficult and many would not undertake such conversations in a main ward because of lack of privacy for all concerned. Real life however does not always provide perfect conditions. I had made a professional

judgement to engage with the patient and recognized that she needed more than just the diagnosis today. She needed to be with her family who were more important to her than doctors.

The staff nurse remained with Mrs X and her husband. The other doctors and I left the ward. One member of the team says "I do not know how you did that! I do not think that I could have told her the way you did." It was is not just about "know-how . It was about having the imagination to see things from the patients perspective and suppress one's own fears and feelings. Such ability is not just bourn out of experience but also about rehearsing in one's own mind what you would do under such circumstances. Sitting down over coffee with my staff allowed me to reveal what exactly I had done, -why I did it that way, and what lay under my visible performance (which is all that the SHO saw). Here I shared ideas about empathy for the patient and my thought: "God what would I do under these circumstances? I explained that I expected her to be upset and even angry, but that I was not afraid of her being so. I also recognised the dynamics of her life which was the most important thing. I opened up my thinking about the fact that nothing actively would be done at the weekend, so that there was a need to engage the right resources before 5pm that Friday, which was why I needed to act immediately. I shared some early experiences (which such incidents always make me recall), that sometimes I had done it badly, and that once, as a PRHO, I had even lied to a patient who, memorably, cautioned me never to do it again. My professionalism as a clinician and a clinical supervisor was demonstrated by this activity of sharing with my staff my experiences and experiential knowledge as well as aspects of me as person who also had feelings.

Follow up

Later Mrs. X came to the clinic as planned. I spent half an hour with her and her husband and children. Once again we covered in detail the options of care and how to deal with the time left. She left the clinic thanking us for our honesty. Ten days later she died at home.

Six weeks later the letter arrived in the complaints office and finally on my desk. Why had no one diagnosed the cancer sooner? There was no complaint about the breaking of bad news on the ward. I planned to see the relatives again in clinic. A colleague to whom I recounted

the story later told me categorically that I was wrong to engage in that kind of discussion at the bedside in an open ward. The colleague argued that I did not "play it by the book".

It is interesting to think how little propositional knowledge the consultant called upon during this particular consultation. It is very pertinent to consider what might have been the outcome if the consultant had not acted in the way he did. Teaching young doctors to understand and develop these abilities is fundamental responsibility of clinical teachers.

Teaching opportunities for this case include:

- **Considering the forms of knowledge doctors need.**
- **Professionalism.**
- **Creating a therapeutic relationship.**
- **Professional judgement and the ability to make 'on the hoof' sound judgements.**

These ideas are explored more thoroughly in *Cultivating a thinking Surgeon,* Linda de Cossart and Della Fish, T*f*M Press, Shrewsbury 2005 and *Developing the Wise Doctor,* Della Fish and Linda de Cossart, RSM Press, London 2007. Seminars run by the authors for ED4MEDPRAC Ltd offer more in-depth development and teaching on these ideas.